DEPARTMENT OF MENTAL RETARDATION
OFFICE OF QUALITY MANAGEMENT, OFFICE OF QUALITY ENHANCEMENT
Follow Up Report

Provider: _____

Location Address: _____ Type of Service: Home □ Work/Community Support □
Site-based Respite □

Team Member(s): _____ Report Date: _____

Follow-up Required: No □ Yes □ If yes, follow-up date: _____

Outcome: People are valued	**Follow-up Results**		
	Corrected	**Partially Corrected**	**Not Corrected**
Areas Needing Improvement: **Findings:**			
Outcome: People's rights are affirmed			
Areas Needing Improvement: **Findings:**			

Outcome: People's rights are protected	Follow-up Results		
	Corrected	Partially Corrected	Not Corrected
Areas Needing Improvement: **Findings:**			
Outcome: People are safe at home and work	**Corrected**	**Partially corrected**	**Not corrected**
Areas Needing Improvement: **Findings:**			

Outcome: People maintain good health	Follow-up Results		
	Corrected	Partially Corrected	Not Corrected
Areas Needing Improvement: **Findings:**			
Outcome: People's funds are safeguarded			
Areas Needing Improvement: **Findings:**			